DOCUMENT RESUME

ED 316 814 CG 022 365

AUTHOR Kilpatrick, Allie C.; Kilpatrick, Ebb G.
TITLE Family Approaches to the Chronically Mentally Ill: Implications for Rural Areas.
PUB DATE Oct 88
NOTE 22p.; Paper presented at the Annual Meeting of the National Association of Social Workers (2nd, Philadelphia, PA, November 9-12, 1988).
PUB TYPE Information Analyses (070) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Chronic Illness; *Family (Sociological Unit); *Mental Disorders; *Rural Areas; Schizophrenia; Trend Analysis

ABSTRACT

The decade of the 1980s has witnessed a rebirth of concern regarding the chronically mentally ill. The way mental health professionals view families of the chronically mentally ill has changed dramatically, largely because of the emergence of the biological theories of causation for schizophrenia. Innovative programs for families have included education, skill-training, supportive and comprehensive components. Findings of effectiveness studies on community-based programs cite the components of family intervention, residential facilities, day treatment, social skills training, problem-solving casework, and community support programs. There are specific implications for family approaches to the chronically mentally ill in rural areas. The closeness of the professionals to the community enhances their ability to mobilize natural helping networks, which is crucial where there is a dearth of resources available. The higher social adjustment of schizophrenics living in rural areas seems to be associated with the higher level of expectations. Of specific interest to rural practitioners is the current farm crisis. The loss experienced by the family of the mentally ill person is compounded by the loss to the family farm. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED316814

FAMILY APPROACHES TO THE CHRONICALLY MENTALLY ILL: IMPLICATIONS FOR RURAL AREAS

by

Allie C. Kilpatrick, Ph.D.

Associate Professor

University of Georgia

Athens, Georgia

Ebb G. Kilpatrick, S.T.M.

Chaplain

Oconee Mental Health Center

Milledgeville, Georgia

CG022365

Keynote address to the Rural Social Work Conference, Georgia Chapter of NASW, Cohutta Lodge, October, 1988.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Allie C. Kilpatrick

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

FAMILY APPROACHES TO THE CHRONICALLY MENTALLY ILL: IMPLICATIONS FOR RURAL AREAS

by

Allie C. Kilpatrick, Ph.D.

Associate Professor

University of Georgia

Athens, Georgia

Ebb G. Kilpatrick, S.T.M.

Chaplain

Oconee Mental Health Center

Milledgeville, Georgia

Invited paper for a special edition of **Human Services in the Rural Environment.** Also to be presented as the keynote address to the Rural Social Work Conference, Georgia Chapter of NASW, Cohutta Lodge, October 1988.

FAMILY APPROACHES TO THE CHRONICALLY MENTALLY ILL: IMPLICATIONS FOR RURAL AREAS

The decade of the 1980s has witnessed a rebirth of concern regarding the chronically mentally ill. According to the National Institute of Mental Health, there are 1.7 million people in this country who are seriously mentally ill. In 1974, the estimation of the cost of mental illness was $36.8 billion for the United States which was equal to 2.5% of the gross national product (Gunderson, 1975). Most of the cost is from the loss of productivity of the people who become patients. Schizophrenia was a major contributor to these costs because of the numbers of individuals it affects, their youth, and the chronic impairments throughout their lives.

A more recent report indicates that the direct and indirect financial costs incurred as a result of the illness in the United States are greater than the total expenditures required for treating all types of cancer combined (Carpenter, 1986). The comparisons of cost per patient reveal that federal support for research on schizophrenia is $7.00 per patient and over $300 per cancer patient.

Actual figures on the incidence and prevalence of schizophrenia are not in any way accurate because there is only data available on treated cases. Torrey (1983) reported that on any given day there are 600,000 people with schizophrenia under active treatment and each year another 100,000 Americans are

diagnosed with it for the first time. A recent estimate was that 40% of persons suffering from psychosis never have received treatment of any kind (Richman & Barry, 1985).

In the past 10 to 15 years, the way mental health professionals view families of the chronically mentally ill has changed dramatically, largely because of the emergence of the biological theories of causation for schizophrenia. There has been a definite paradigm shift from the idea that disturbed family interactions led to one member's schizophrenic reaction to the converse that family processes may become dysfunctional as a result of one member becoming schizophrenic (Walsh, 1988). The basis for this shift is presented by Taylor (1987) from research conducted at the National Institute of Mental Health. He states that "biological science is close to proving empirically that schizophrenia is a neuropathological disease process" (p. 115).

Concurrently with this theoretical shift have come dramatic changes in our understanding of the dimensions of need among chronic mental patients and among those whose lives are most affected by their illness - that is, their families. Families have become the primary caretakers for most chronic shcizophrenics living in the community (Lamb, 1982). A major catalyst in this awakening is the phenomenal growth of what has come to be known as the "family movement."

This paper presents state of the art research findings concerning dynamics of and effective treatment models with the chronically mentally ill with an emphasis on those dynamics and

models which involve the family of the patient. Special characteristics of the rural environment and how they impact the families and the process of treatment of the chronically mentally ill are discussed.

Current Knowledge

One of today's strongest areas of social work research is that of community-based care of the chronically mentally ill (Rubin & Gibelman, 1984). Several well-done reviews of the literature have been conducted in recent years. Cole and Cole (1987) summarized the findings of their review concerning our current knowledge of chronic schizophrenia and its treatment:

1. It appears that the schizophrenic syndrome may be the manifestation of an underlying brain disease.

2. Therefore, the occurrence of schizophrenia may not be attributed either to faulty upbringing or to poor character.

3. The majority of patients eventually get better.

4. Overstimulation of the patient may result in early relapse.

5. Neuroleptic medication is the most effective deterrent to relapse.

6. Tardive dyskinesia and certain severe residual states can be prevented through programs of controlled medication reduction.

7. Patients can reduce overstimulation through the acquisition of more effective techniques for coping with life stress.

8. If provided with information and helpful suggestions,

family members can become essential components of the treatment team.

9. Relatives and members of the treatment team can be taught to reduce patient overstimulation.

10. Psychosocial treatment is only effective for patients receiving carefully titrated medication.

11. The best treatment programs provide continuity of care within a comprehensive network of supportive services coordinated through case management.

12. Programs providing aggressive community outreach and in vivo patient and family contact are more effective than office- or facility-based programs.

13. Patients and their families may benefit considerably by joining self-help groups composed of other patients with schizophrenia and their families. (p. 293)

A basic underlying theory leading to this summary is found in the biopsychosocial model (Neuchterlein & Dawson, 1984). The basic deficit appears to consist of an inability to handle complex information, a concommitant breakdown in attention-focusing mechanisms associated with hyperarousal of the autonomic nervous system, and subsequent deterioration in interpersonal functioning (Ciompi, 1983). The biopsychosocial model states that a genetic vulnerability may "allow the individual to develop the syndrome in the face of certain environmental triggers" (Cancro, 1982, p. 96), stressful life

events (SLE), or tension-laden relationships with significant others that overwhelm the vulnerable person's defenses and coping mechanisms (Zubin, Magaziner, & Steinhauer, 1983). A series of British studies established a strong correlation between the level of expressed emotion (EE) shown by relatives and the outcome of schizophrenia in patients living with them. High-EE relatives are said to be intrusive, overprotective,and self-sacrificing (Vaughn & Leff, 1981).

A growing number of studies have attempted systematicaly to assess the needs of families by directly asking family members to report on what they need to be effective care givers for their disabled relative. The samples used from most of these studies are drawn from existing self-help groups, such as chapters of the National Alliance for the Mentally Ill (NAMI). Although the NAMI is not representative of all families of the mentally ill - NAMI families are primarily middle-and upper class, and few are from minority groups, the results are useful in describing the needs of families with psychiatrically disabled relatives. Spaniol and Zipple (1986) summarized these findings:

1. Families should be seen as reactors to the mental illness of one of their members rather than the cause of the disorder.

2. In many cases, families have become the primary care givers for their mentally ill family member. Families are not satisfied with this situation, and they feel abandoned by the mental health system.

3, Families with mentally ill members need special skills,

information, and support in their care-giving efforts. Meeting these needs benefits the entire family, including the ill family member.

4. Traditional family therapy is not a service that is desired by most families with mentally ill members. Families with mentally ill members have many strengths, and many report that they are coping adequately with their ill member.

5. Mental health professionals should be educators and consultants to families with mentally ill members. Professionals should provide the skills, information, and support that families need to cope with and care for their ill family members.

A study by the Georgia Alliance for the Mentally Ill (Conn and Francell, 1986) which was not included in this review found that families also saw an urgent need for changes in laws concerning involuntary commitment and confidentiality.

Innovative Approaches

There has recently been increased interest in developing and evaluating interventions that meet the self-perceived needs of families with mentally ill members. The most important innovations in assistance to families has been in providing education and support. There now exists a growing body of evidence that these approaches result in significantly improved outcomes for the disabled family member (Anderson, Hogarty & Reiss, 1981; Byalin, Jed & Lehman, 1982; Faloon, Boyd, Mcgill et al., 1982).

A survey of existing approaches to assisting families with a

chronically ill member (Spaniol & Zipple, 1986) found that they can be divided into four general categories:

1. Educational approaches designed primarily to provide information

2. Skill-training approaches designed to develop skills

3. Supportive approaches designed to enhance the family's emotional capacity to cope with stress

4. Comprehensive approaches that incorporate information, skill training, and support in a single intervention.

It is not clear, however, that any of these approaches offers a distinct advantage over the others in client outcome. Each of the models seems to be equally effective in reducing the relapse rate of the mentally ill family member. The reasons for this similarity in effectiveness may be that such global outcome indicators as relapse or recidivism rates may be too broad to capture significant differences, and that each of the models shares a core group of common features, resulting in similar outcomes. Most models do use elements of more than one of these approaches, and they also relate directly to what families have been saying they want or need from professionals (Spaniol & Zipple, 1986).

In order to determine what constitutes effective community-based care of chronic mental illness, Rubin (1985) reviewed only the experimental outcome studies that randomly assigned clients to service or control groups or to groups receiving alternative forms of treatment. He acknowledges the problems with the

diversity of definitions of the chronically ill, and states that the tested interventions are deemed effective not because they cured psychopathology, but because they enhanced the living conditions or facilitated the role performance of those suffering from psychopathology (care not cure). The studies reviewed point to the effectiveness of the following interventions when combined with drug therapy in maintaining certain subgroups of the chronically impaired in the community, facilitating their role performance,and enhancing their living conditions.

1. Family intervention with an educational focus on understanding and coping with patients' disabilities and on diminishing family pressures and overstimulation.

2. Residential facilities that stress fundamental components of problem-solving, task-centered, and behavioral models of practice.

3. Day treatment services that emphasize social interaction and occupational therapy and which deemphasize intensive psychological therapies that might harm those schizophrenic patients unable to cope with high levels of cognitive arousal.

4. Social skills training, combined with day treatment, that utilizes behavioral methods such as modeling, role-playing, feedback, and positive reinforcement.

5. Problem-solving casework focusing on major role performance - but only for patients receiving drug therapy and deemed able to cope with the stimulation and increased expectations associated with this treatment.

6. Community support programs that provide a comprehensive range of services, including the five mentioned previously, as well as case managers who help clients secure essential material resources, learn basic living skills, acquire a support system, and utilize medication and other components of the treatment plan. (pp. 12-13).

Rubin warns that the positive effects of most of these interventions are maintained only as long as they are being carried out. When the interventions are discontinued, the positive results tend to reverse. Thus, these services may have to be made available in an ongoing, not a time-limited, fashion, and in the context of social care, not cure. He also reiterates that there is much variation among chronic patients in their capacity to handle stress. pressure, and stimulation - and ultimately in their capacity for rehabilitation.

Families: A Key Ingredient

There is a growing acknowledgment of the crucial role that family members play in providing primary care and aftercare as a result of deinstitutionalization. With approximately 70% of mental patients returning to their homes, the heavy burden assumed by family members is recognized (Goldman, 1982).

Family Programs. Building upon research findings such as those reviewed previously, various types of programs have been developed which recognize families as key ingredients in the care-taking process. Taylor (1987) states that the schizophrenic should live in whichever environment maximizes the quality of

life for all family members, empowers parental figures, ensures continued support by the family, and results in fewer hospitalizations.

He proposes assessing the family environment in order to clarify specific issues when evaluating whether an individual is best assisted by the family in or away from home. The issues include the level of independence of the patient, roles that families need to perform, strengths and resources of family, community resources, emotional and financial cost to family, and the environmental setting where the patient has the highest level of of functioning. Taylor believes that the family is often the best advocate and case manager available to individuals with schizophrenia.

A family educational intervention plan is proposed by Walsh (1988). His plan would cover the five areas of diagnosis, medications, community resources, therapy techniques, and engaging the unmotivated client relative. He provides guidelines for social worker educators which are relevant to the families' needs.

A more comprehensive psychoeducational model is adapted by Iodice & Wodarski (1987) from one presented by Anderson, Hogarty & Reiss, (1980)who stated about their model:

> a variety of supportive and educational techniques are used to lower the emotional temperature of the family while maintaining sufficient pressure on patients to avoid the pitfalls of negative symptoms. (p. 492)

This model describes four phases of aftercare of schizophrenic patients with goals and techniques for each phase. The phases are (I) connection, (II) survival skills workshop, (III) reentry and application, and (IV) maintenance. Phase I of this long-term, highly structured and supportive model begins at the time of the patient's hospital admission and Phase IV is on-going.

A comprehensive intervention package called the Family Support Project is reported by Ferris and Marshall (1987). Knowledge, skills and group support are integral parts of this approach. They concur with Torrey's (1983) observation that "families do not need to be 'treated,' but rather educated" (p. 159). The first phase in this project identifies family needs in a small group of families. The second phase consists of a crisis-oriented two-hour weekly group for families for five or six weeks, and then nine two-hour weekly sessions of a structured educational program. Skill training for nine additional weeks in groups of families is the third phase of the program. The fourth phase consists of a long-term support group in which the families meet once monthly , and in the final phase education, skills, and support come together as a catalyst to strengthen families and to provide the group cohesiveness necessary for families to continue forward as a unit.

Another model considers the role of the family in case management. Intagliata, Willer and Egrl (1986) presents a systematic discussion of family members' actual and potential contributions to each of six specific aspects of the case

management process. These aspects include assessment, linking, monitoring, assistance in daily living, crisis intervention and advocacy. For each of these functions, they list the activities of both family members and professionals. All of these are brought together and depicted in a handy chart which gives specific activities to be performed by each.

A Neglected Area. An areas which is often neglected when working with families of the chronically mentally ill is that of loss and mourning. Family members and the patient must come to terms emotionally as well as intellectually with the illness. Families may go through a highly traumatic sense of loss and need to go through the grief process. Each should be encouraged to explore the dreams they once had for the ill member, and to grieve the loss of the member's mental health and problem-solving abilities. Family members also need to be helped to grieve practical, concrete personal losses such as time, money, recreation, attention, and possible job choices. Living with a mentally ill family member is an emotionally taxing experience. Taylor (1987) states that the tangible and abstract personal costs of schizophrenia for each family member should be explored and authenticated by the social worker.

A further complicating factor to the grief process is that the family's loss and mourning may go unrecognized by those around them because there has been no actual bodily death. Although the literature is devoid of any significant discussions of loss and mourning as they relate to mental illness, Wikler,

Wasow and Hatfield (1981) did study family reaction to mental retardation in a child. They observed what they termed as chronic sorrow, and saw it as a normal reaction to an abnormal situation. This phenomenon could also be applicable to families of the chornically mentally ill.

Going through the grief process is one way that families can take care of themselves while providing the emotionally taxing care-giving function. In order to reorganize around the loss of nornal functioning of the family member, families must develop a wide variety of techniques to take care of themselves and to prevent exhaustion. Spaniol (1987) discusses personal strategies that some families have developed for this purpose. These include acceptance of various components of the situation, distancing themselves from things they cannot change or for which they cannot assume responsibility, and setting limits on emotions as well as behavior.

Implications for Rural Areas

Factors such as closeness between practitioners and community, isolation of communities, and symptomatology and social adjustment of the rural mentally ill have implications for rural areas.

Closeness and Isolation. Existing literature on rural mental health practice as summarized by Boyer (1987) cites two types of environmental factors which affects practitioners. On the one hand, rural environments promote unusual closeness between practitioners and community, and on the other hand the

characteristics of geographic isolation, isolation from colleagues and lack of specialized resources create a sense of separation between rural communities and the rest of the world. Both these factors have implications for families of the chronically mentally ill. The closeness factor could facilitate the helping process with families, especially the mobilization of helping networks. The isolation factor could limit the available resources for service to families.

Symptomatology and Social Adjustment. Numerous significant differences were found in symptomatology and social adjustment between urban and rural schizophrenics as reported by both patients and their relatives (Chu, Sallach, & Klein, 1986). Urban schizophrenics reported lower expectations for performance of social activities than rural schizophrenics. Urban schizophrenics were perceived by relatives to be more helpless, suspicious, nuervous, bizarre, hyperactive and less emotionally stable than rural schizophrenics. According to relatives' evaluations, urban schizophrenics performed less in social activities and participated less in leisure-time activities then rural schizophrenics. Relatives of urban schizophrenics were also found to have lower expectations for patients' performancer of social activities than their rural counterparts. The implications here are that the findings suggest that a higher level of expectations of social activities from schizophrenic patients and their relatives leads to higher performance of social activities in schizophrenic patients. This could compensate for the lack of

resources found in rural areas.

The Farm Crisis. A current implication is found in the farm crisis. Usually farming is an industry that is handed down from one generation to another. Children are looked upon as individuals who can assume the business of the farm, and be able to carry on the tradition of this farm family. If this does not occur, a complete over-haul of one's dreams and aspirations and a scale-down of what one hopes to obtain in life is necessary.

When mental illness strikes a member of the family and the individual is unable to accept this kind of responsibility, there is the loss of this dream and expectation of the fulfillment of family goals. Adjusting to this loss is extremely difficult. Therefore, the rural professional needs to spend time in helping the family to articulate their goals, dreams, and aspirations. It is easier to talk about the loss of a concrete object, tractor, house, etc. than to talk about the loss of a dream or fantasy that one has for their offspring and for the next generation. The loss is doubled for the family with a chronically ill member, as previously discussed, when a farm is also involved. The healing process is thus compounded. Family work should help to lift up this kind of information, encourage the family to mourn, and assist them in moving through the grief process to a healthy resolution.

Summary and Conclusions

The purpose of this paper was to present family approaches to the chronically mentally ill with a special emphasis on the

implications for rural areas. The current emphasis on biopsychosocial models was reviewed. A recent development has been the attention paid to family needs which was a outgrowth of the grass roots family movement. Innovative programs for families have included education, skill-training, supportive and comprehensive components. Findings of effectiveness studies on community-based programs cite the components of family intervention, residential facilities, day treatment, social skills training, problem-solving casework and community support programs. Families are shown to be a key ingredient in maintaining the chronically mentally ill in communities. A neglected area which should be emphasized more is dealing with the dynamics of loss and mourning for the family's ideals and expectations for the mentally ill member.

There are specific implications for family approaches to the chronically mentally ill in rural areas. The closeness of the professionals to the community enhances their ability to mobilize natural helping networks, which is crucial where there is a dearth of resources available. The higher social adjustment of schizophrenics living in rural areas seems to be associated with the higher level of expectations.

Of specific interest to rural practitioners is the current farm crisis. The loss experienced by the family of the mentally ill person is compounded by the loss to the family farm of the services of that person. This could be a factor in some of the close downs of family farms.

References

Anderson, C., Hogarty, G, & Reiss, D. (1980). Family treatment of adult schizophrenia patients: A psycho-educational approach. Schizo Plunca Bulletin, 6(3) p. 495.

Anderson, C., Hogary, G. & Reiss, D. (1980). The psychoeducational family treatment of schizophrenia. In M. Goldstein (Ed.), New directions for mental health seminar: New development in interventions with families of schizophrenia, No. 12. San Francisco: Jossey-Bass.

Bagarozzi, D. A. (April 1982). The family therapists role in treating families in rural communities: A general system approach. Journal Marital and Family Therapy. 8(2) pp. 51-58.

Boyer, P.A. (1987). Rural marriage and family therapy: Skills for private practice. Human Services in the Rural Environment, 10(2), pp. 18-23.

Byalin, K., J.J. & Rehamm, S. (1982). Family intervention with treatment - refractory chronic schizophrenia. Paper presented at 20th International Congress of Applied Psychology, Edinburgh, Scotland.

Cancro, R. (1982). The role of genetic factors in the etiology of the schizophrenia disorders. In L. Griuspoon (Ed.), Psychiatry 1982: Annual Review (pp. 92-97). Washington, D.C.: American Psychiatric Press.

Carpenter, W.T., & Keith, S.J. (March, 1986). Integrating treatment in schizophrenia Psychiatric clinics of North America.

Chu, C., Sallach, H.S., & Klein, H.E. (1986). Differences in symptomatology and social adjustment between urban and rural schizophrenia. Social Psychiatry, 21 pp. 10-14.

Cionipi, L. (1983). How to improve the treatment of schizophrenia: A multi-causal concept and its therapeutic components. In H. Stierlin, L.C. Wynn & M. Wirschung (Eds.), Psychosocial intervention in schizophrenia: An international view. New York: Springer-Verlag, pp. 53-66.

Cole, S.A. & Cole, D.S. (1987). Professionals who work with families of the chronic mentally ill: Current status and suggestions for clinical training. In A.B. Hatfield & H.P. Leffey, Families of the mentally ill: Coping and adaptation. NY: The Suilford Press, 1987, pp. 278-306.

Corn, V., & Francell, C.G. (1986). Mental health provider systems in Georgia: Concerns of families of the prolonged mentally ill Georgia. Georgia Alliance for the Mentally Ill for the Division of Mental Health & Mental Retardation, Department of Human Resources.

Craig, B. & Hurry, D. (1981). Rural multi-problem families. Journal of Family Therapy, 3, pp. 91-99.

Craig, T.J.H. et. al. (May 1987). Family support programs in a regional mental health system. Hospital & Community Psychiatry, 38(5), pp. 459-460.

Falloon, I., Boyde, J., McGill, C., Razani, J., Moss, H., & Gilderman, A. (1982). Family management in the prevention of eracertation of schizophrenia: A controlled study. New England Journal of Medicine, 306, pp. 1437-1440.

Falloon, R.H., Boyd, J.L., & McGill, C.W. (October 1985). Journal of Marital & Family Therapy.

Falloon, R.H., Boyd, J.L., & McGill, C.W. (October, 1985). Journal of Marital & Family Therapy. Family care of schizophrenia: A problem-solving approach to the treatment of mental illness. NY: Guilford Press, 1984.

Ferris, P.A. & Marshall, C.A. (1987). A model project for families of chronically mentally ill. Social Work, 32(2) pp. 110-114.

Goldman, H.H. (1982). Mental illness and family burden: A public health perspective. Hospital and Community Psychiatry, 33, pp. 557-560.

Gunderson, J.G. (1975). The cost of schizophrenia. American Journal of Psychiatry, 132, pp. 901-906.

Hatfield, A.B. (1987). Consumer Issues in Rural Areas. In M.P. Keenan, Ed. The chronically mentally ill in rural areas: Model curricula for social work education, Rockville, Maryland: U.S. Department of Health & Human Services, pp. 165-175.

Hatfield, A.B., & Lelley, H.P. (1987). Families of the mentally ill: Coping and adaptation. NY: The Guilford Press.

Intagliata, J., Willer, B., & Egrl, G. (1986). Role of the family in case management of the mentally ill. Schizophrenia Bulletin, 12(4), pp. 699-706.

Iodice, J.D., & Wodarski, J.S. (1987). Aftercare treatment for schizophrenia living at home. Social Work, 32(2), pp. 122-129.

Lama, H.R. (1982). Treating the long-term mentally ill. San Fransico: Jossey-Bass.

Neuchterlein, K.H., & Dawson, M.E. (1984). A heuristic vulnerability/stress model of schizophrenia episodes. Schizophrenia Bulletin, 10, 300-312.

Paradis, B.A. (1987). An integrated team approach to community mental health. Social Work, 32(2) pp. 101-108.

Rapp, C.A. (1985). Research on the chronically mentally ill: Curriculum implications. In J.P. Bowker, Ed., Education for practice with the chronically mentally ill: What works? Washington, D.C.: CSWE pp. 32-49.

Richman, A., & Barry, A. (1988). More and more is less and less: The myth of massive psychiatric need. British Journal of Psychiatry pp. 146, 164-168.

Rohrbaugh, M. (1983). Family therapy & schizophrenia research: Swimming against the mainstream. Networker pp. 29-31.

Rubin, A. (1985). Effective community based care of chronic mental illness: Experimental findings. In J.B. Bowker, Ed., Education for practice with the chronically mentally ill: What works? Washington, D.C.: CSWE, pp. 1-17.

Rubin, A. (1986). Review of current research on chronic mental illness. In J.P. Bowker & A. Rukin, Eds. Studies on chronic mental illness: New Horizons for social work researchers. Washington, D.C., Cowert on Social Work Education, pp. 5-28.

Rubin, A., & Gibelman, M. (1986). Social work research in mental health: The state of the art. Rockville, MD: National Institute of Mental Health.

Spanial, L. (1987). Coping strategies of family caregivers. In Hatfield, A.B. & Leffey, H.P., Families of the mentally ill: Coping and adaptation, pp. 208-222.

Spanial, L., & Zipple, A. (1986). Families with a chronically mentally ill member: A review of the research findings. In J.P. Bowker & Rubin, Eds. Studies on chronic mental illness: New horizons for social work researchers. Washington, D.C.: CSWE, pp. 52-82.

Taylor, E.H. (March-April 1987). The biological basis of schizophrenia. Social Work, 32(2), pp. 115-121.

Todd, D.M., & Armstrong, D. (Summer 1984). Support system of elders in rural communities. International Journal of Family Therapy, 6(2) pp. 82-92.

Torrey, E.F. (1983). Surviving schizophrenia. New York: Hayer & Row.

Vaugh, C.E., & Leff, J.P. (1981). Patterns of emotional response in relatives of schizophrenia patients. Schizophrenia Bulletin, 7(1), pp. 43-44.

Walsh, J. (March-April 1988). Social Workers as family educators about schizophrenia. Social Work, 33(2) pp. 138-141.

Wiebler, L., Wason, M. & Hatfield, E. (1981). Chronic sorrow revisited: Parents vs. professional depiction of the adjustment of parents of mentally retarded children. American Journal of Orthopsychiatry, 51, 63-70.

Wodarski, J.S. (1983). Rural community mental health practice. Baltimore: University Park Press.

Zubin, J., Mazaziner, J. & Steinhaner, S.R. (1983). The metamorphosis of schizophrenia: From chronicity to vulnerability. British Journal of Psychiatry pp. 143, 551-571.